# Dental
# Master Group Policy
# And
# Enrollee Certificate

GROUP POLICY

FOR

State of Idaho

Group #10040000

Effective Date: July 1, 2010

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# DENTAL
# MASTER GROUP POLICY
# BENEFITS OUTLINE

This Benefits Outline describes the benefits of this Policy in general terms. It is important to read the Policy in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions.

Throughout this Policy, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Policy, Maximum Allowance is the amount established as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section.

To locate a Contracting Provider in your area, please visit our Web site at www.bcidaho.com and login as a member. You may also call our Customer Services Department at 208-331-8897 or 866-804-2253 for assistance in locating a Provider.

**ELIGIBILITY AND ENROLLMENT**

Eligible Employees are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week and whose term of employment is expected to exceed five (5) continuous months.

Employees hired on or after the effective date of this Policy will have coverage for him or herself and their Dependent(s) effective the first day of the month following ninety (90) days of employment, provided enrollment is completed within thirty (30) days of the date of hire. The following exceptions apply: Benefits for employees *rehired* within twelve (12) months of the last date of employment with the state and who were eligible for benefits on date of termination will be effective on the first day of the month following the date of rehire, provided enrollment is completed within (30) days of rehire date. Eligible Employees who remain employed but lose coverage due to a reduction in hours or who choose not to self-pay during periods of leave without pay will have their coverage resume the first day of the month following the date they return to eligibility or active status, provided a new enrollment form is completed within thirty (30) days of the date they return to benefit-eligible status.

*(see the Policy for additional Eligibility and Enrollment provisions)*

| DENTAL CARE BENEFITS | |
|---|---|
| **For Covered Providers and Services** | |
| Benefit Limit | $1,000 per Insured, per Benefit Period |
| Orthodontic Lifetime Limit | $1,000 per Insured |
| **Deductible:**<br>Individual | Insured pays $25 per Benefit Period<br>(Deductible does not apply to Preventive/Diagnostic Dental Covered Services received from a PPO Contracting Provider) |

| DENTAL CARE BENEFITS | | | |
|---|---|---|---|
| | **In-Network** | | **Out-of-Network** *(When you choose an Out-of-Network Provider you are responsible for the difference between what BCI allows and what the Out-of-Network Provider charges)* |
| | **PPO Contracting Providers** | **Traditional Contracting Providers** | |
| **Preventive/Diagnostic Dental Services** | BCI pays 80% of Maximum Allowance | BCI pays 70% of Maximum Allowance after Deductible | BCI pays 70% of Maximum Allowance after Deductible |
| **Other Dental Services**<br>(Occlusal Guards, Sealants, Amalgam Restorations and Resin-Composite Restorations) | BCI pays 80% of Maximum Allowance after Deductible | BCI pays 70% of Maximum Allowance after Deductible | BCI pays 70% of Maximum Allowance after Deductible |
| **Basic Dental Services** | BCI pays 80% of Maximum Allowance after Deductible | BCI pays 50% of Maximum Allowance after Deductible | BCI pays 50% of Maximum Allowance after Deductible |
| **Major Dental Services**<br>*(Implants are limited to a lifetime Benefit Limit of $900 per tooth, per Insured)*<br><br>Twelve (12) month waiting period for Crowns, Bridges, Dentures and Dental Implants for new Enrollees. | BCI pays 50% of Maximum Allowance after Deductible | BCI pays 50% of Maximum Allowance after Deductible | BCI pays 50% of Maximum Allowance after Deductible |

| | | | |
|---|---|---|---|
| **Orthodontic Services**<br>*(for eligible dependent children up to age 19 if the treatment has begun by age 17)*<br><br>Twelve (12) month waiting period for Orthodontic Services for new Enrollees | BCI pays 50% of Maximum Allowance | BCI pays 50% of Maximum Allowance | BCI pays 50% of Maximum Allowance |

**ACCEPTANCE**

In consideration of the accepted Blue Cross of Idaho fully insured proposal, and the continuing payment of premiums when due, and subject to all terms of this Policy, Blue Cross of Idaho hereby agrees to provide each enrolled Insured of the Group the benefits of this Policy (Group Policy Number 10040000), beginning on each Insured's Effective Date.

This Policy renews on an annual basis. Premium payments are due on a month-to-month basis. The Group's Policy Date is July 1, 2010 to June 30, 2011.

State of Idaho
Department of Administration
650 West State Street
P.O. Box 83720
Boise, ID 83720-0003

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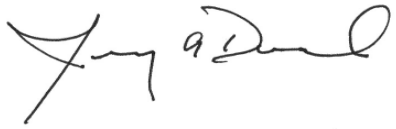
J. Michael Gwartney
Director, Department of Administration

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707



Jerry A. Dworak
Sr. VP & Chief Marketing Officer
July 1, 2010

## HOW TO SUBMIT CLAIMS

An Insured must submit a claim to Blue Cross of Idaho (BCI) in order to receive benefits for Covered Services. There are two ways for an Insured to submit a claim:

1. The Provider can file the claims for the Insured. Most Providers will submit a claim on an Insured's behalf if the Insured shows them a BCI identification card and asks them to send BCI the claim.

2. The Insured can send BCI the claim.

**To File An Insured's Own Claim**
If a doctor, Dentist, hospital, or other Covered Provider prefers that an Insured file the claim, here is the procedure to follow:

1. Ask the Dentist or other Covered Provider for an itemized billing. The itemized billing should show each service received and its procedure code, the date each service was furnished, and the charge for each service. BCI cannot accept billings that only say "Balance Due," "Payment Received" or some similar statement.

2. Obtain a Member Claim Form from the Covered Provider or any of BCI's offices, and follow the instructions. Use a separate billing and Member Claim Form for each patient.

3. Attach the billing to the Member Claim Form and send it to:

   Blue Cross of Idaho Claims Control
   Blue Cross of Idaho
   P.O. Box 7408
   Boise, ID 83707

For assistance with claims or health benefit information, please call BCI Dental Customer Service at 1-866-804-2253-or (208) 331-8897.

**How Blue Cross Of Idaho Notifies The Insured**
BCI will send the Insured an Explanation of Benefits (EOB) as soon as the claim is processed. The EOB will show all the payments BCI made and to whom the payments were sent. It will also explain any charges BCI did not pay in full. Insureds should keep this EOB for their records.

## BLUE CROSS OF IDAHO DISTRICT OFFICE LOCATIONS

For general information, please contact your local Blue Cross of Idaho office:

***Boise Office***
Blue Cross of Idaho
Customer Services Department
3000 East Pine Avenue
Meridian, ID 83642

*Mailing Address*
P.O. Box 7408
Boise, ID 83707
(208) 331-7699 (Boise Area)
1-800-627-1006

***Lewiston Office***
Blue Cross of Idaho
1010 17th Street
Lewiston, ID 83501

*Mailing Address*
P.O. Box 1468
Lewiston, ID 83501
(208) 746-0531

***Coeur d'Alene Office***
Blue Cross of Idaho
2100 Northwest Blvd., Suite 120
Coeur d'Alene, ID 83814
(208) 666-1495

***Pocatello Office***
Blue Cross of Idaho
275 South 5th Avenue, Suite 150
Pocatello, ID 83201

*Mailing Address*
P.O. Box 2578
Pocatello, ID 83206
(208) 232-6206

***Idaho Falls Office***
Blue Cross of Idaho
2116 E 25th St.
Idaho Falls, ID 83404

*Mailing Address*
P.O. Box 2287
Idaho Falls, ID 83403
(208) 522-8813

***Twin Falls Office***
Blue Cross of Idaho
1431 N. Fillmore St., Suite 200
Twin Falls, ID 83301

*Mailing Address*
P.O. Box 5025
Twin Falls, ID 83303
(208) 733-7258

## IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

*Idaho Department of Insurance*
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

## DENTAL BENEFITS SECTION

This section specifies the benefits an Insured is entitled to receive for the Dental Covered Services described, subject to other provisions of this Policy.

**I. Benefit Period and Benefit Limits For Covered Services**

The Benefit Period and the Benefit limits are shown in the Benefits Outline.

**II. Covered Providers**

The following are Covered Providers under this section:

- Dentist
- Denturist

**III. Deductibles**

The individual Deductible is shown in the Benefits Outline.

**IV. Predetermination of Benefits**

A recommended Dental Treatment Plan must be submitted to Blue Cross of Idaho (BCI) for a Predetermination of Benefits before treatment begins if the Plan includes one (1) or more of the following procedures:

**A.** Bonding Procedures
**B.** Bridgework
**C.** Crowns
**D.** Full or Partial Dentures
**E.** Inlays/Onlays
**F.** Laminate Veneers
**G.** Periodontal Surgery
**H.** Surgical Removal of Impacted Teeth
**I.** Implants

The Dental Treatment Plan must be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials requested by BCI or the Dental Consultant(s).

BCI will notify the Insured and his or her Dentist of the benefits available based upon the Dental Treatment Plan. In determining the amount of benefits available, BCI or the Dental Consultant(s) considers whether alternate procedures would accomplish a professionally satisfactory result. If the charges or fees for the treatment chosen by the Insured and his or her Dentist exceed the charges or fees for the treatment BCI has determined will accomplish a professionally satisfactory result, then BCI will only provide benefits based on the charges or fees for the less costly treatment.

If an Insured submits a claim for completed treatment that includes services in the above listed categories, and benefits have not been predetermined by BCI, the claim is reviewed in the same manner as if it were being submitted for a Predetermination of Benefits. BCI or the Dental Consultant(s) will consider whether alternate procedures would have accomplished a professionally satisfactory result. If the Insured and his or her Dentist have chosen a more expensive method of treatment than is determined professionally satisfactory by BCI, the excess charge is solely the responsibility of the Insured, whether services are provided by a Contracting or Noncontracting Provider.

A Predetermination of Benefits is valid for six (6) months from the date it is issued. After six (6) months, a Dental Treatment Plan must be resubmitted for a new Predetermination of Benefits before treatment begins. All Predetermination of Benefits will be processed without taking into consideration dental benefits that may be paid under another certificate of insurance.

**V. Amount Of Payment**

Unless stated otherwise, if Dental Covered Services are rendered by a Dentist outside the state of Idaho, BCI will provide the same benefits as described for an in-state Contracting Dentist.

A Contracting Dentist rendering Covered Services as described shall not make an additional charge to an Insured for amounts in excess of the Maximum Allowance except for Deductibles, Coinsurance, and noncovered services.

Except as stated elsewhere in this Policy, BCI will pay benefits for Preventive, Other, Basic, Major and Orthodontia Dental Covered Services after an Insured has satisfied his or her Deductible, if applicable. The reimbursement schedule is shown in the Benefits Outline.

Benefits for Orthodontic Services are paid as follows:

**A.** BCI will pay benefits on the patient's initial banding.

**B.** Thereafter, BCI will pay benefits up to the Orthodontic lifetime benefit limit as Covered Services are performed so long as the Insured continues orthodontic treatment and remains covered under this Policy.

**A. Dental Services From A Contracting Dentist**
A Contracting Dentist in or outside the state of Idaho rendering Covered Services as provided in this section shall not make an additional charge to an Insured for amounts in excess of the Maximum Allowance except for Deductible, Coinsurance, and charges for noncovered services, if any.

**B. Dental Services From A Noncontracting Dentist**
A Noncontracting Dentist in or outside the state of Idaho is not obligated to accept the Maximum Allowance as payment in full. BCI is not responsible for the difference, if any, between BCI's payment and the actual charge, unless otherwise specified. Insureds are responsible for any such difference, including Deductibles, Coinsurance, Copayments, charges for noncovered services, and the amount charged by the Noncontracting Dentist in excess of the Maximum Allowance.

## VI. Closed List Of Dental Covered Services

The following is a complete list of Dental Covered Services for which benefits are available. Only those services included on this list are eligible for payment.

There are no waiting periods for benefits except as stated in the following list of Dental Covered Services or in the exclusions and limitations provisions.

**A. Type I: Preventive/Diagnostic Dental Services**

1. Oral examination—limited to once in a six (6) month period.
2. Emergency oral examination—covered for trauma, acute infection, or acute pain.
3. Complete mouth series or panoramic x-ray—limited to one (1) time in any five (5) consecutive years, unless requested by BCI for verification of treatment claimed.
4. Individual periapical x-rays—limited to the same benefit as a complete mouth series or panoramic x-ray. Individual periapical x-rays are not covered when performed during root canal therapy as an intra-operative procedure.
5. Occlusal x-rays—limited to once per Benefit Period.
6. Extraoral x-rays—limited to once per Benefit Period.
7. Bitewing x-rays—limited to once every twelve (12) months. Limited to the same benefit as a complete mouth series or panoramic x-ray.
8. Dental prophylaxis—limited to one prophylaxis every six (6) months regardless of type (dental prophylaxis or periodontal maintenance).
9. Fluoride treatments—limited to one (1) application every twelve (12) months and limited to Insureds who are Eligible Dependent children under the age of twenty (20).
10. Palliative treatment—paid as a separate benefit only if no other treatment is rendered during the visit.
11. Biopsy of soft or hard oral tissue (for removal of specimen only).
12. Full Mouth Debridement—limited to one time in a three (3) year period.
13. Space maintainers—limited to Insureds who are Eligible Dependent children under age eighteen (18). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.
14. Periodontal maintenance/prophylaxis—limited to once in a six (6) month period. Benefits are limited to one (1) prophylaxis every six (6) months regardless of type (dental prophylaxis or periodontal maintenance).

**B. Type II. Other Dental Services**

1. Topical application of sealants per tooth—limited to permanent posterior unrestored dentition of Eligible Dependent children under age sixteen (16). Also limited to one (1) time per tooth in any three (3) consecutive years.
2. Occlusal guard—covered for erosion or abrasion limited to one (1) appliance every two (2) Benefit Periods.
3. Amalgam restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of surfaces treated. Same tooth surface restoration is covered once every twenty-four (24) months.
4. Resin-Composite restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of surfaces treated. Same tooth surface restoration is covered once every twenty-four (24) months.

**C. Type III: Basic Dental Services**

1. Pin retention.
2. Simple extractions.
3. Surgical removal of an erupted or partially erupted tooth or mucoperiosteal flap or incision of soft tissue.
4. Impaction that requires incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of the tooth (extraction of tooth, partial bony impaction).
5. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal (extraction of tooth, complete bony extraction).
6. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances (including report).
7. Root recovery.
8. Excision of pericoronal tissues.
9. Tooth reimplantation.
10. Alveoloplasty and alveolectomy—not separately payable if performed on the same date as extraction.
11. Removal of exostosis.
12. Frenectomy (frenulectomy).
13. Excision of hyperplastic tissue.
14. Incision and drainage.
15. Radical excision (lesion diameter up to or greater than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
16. Excision pericoronal gingiva (operculectomy).
17. Excision of benign tumor (lesion diameter up to or greater than 1.25 cm) —not payable in addition to extraction performed in same site on same date.
18. Removal of odontogenic cyst or tumor (diameter up to or greater than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
19. Suture of small wounds.
20. General anesthesia—covered as a separate benefit only if BCI reasonably determines that it is required for complex and/or oral surgical procedures covered under this Policy.
21. I.V. sedation—covered as a separate benefit only if BCI determines that it is reasonably required for complex and/or oral surgical procedures covered under this Policy.
22. Pulpotomy.
23. Root canal therapy—multiple endodontic treatments, on the same tooth within a period of one (1) year, are subject to review and approval by BCI.
24. Apicoectomy and retrograde filling—paid as a separate benefit only if performed more than twelve (12) months after the root canal therapy is completed.
25. Hemisection.
26. Scaling and root planing—limited to once per quadrant of the mouth, every three (3) years.
27. Gingivectomy—one (1) such surgical procedure per quadrant, once every three (3) years.
28. Osseous Surgery—one (1) such surgical procedure per quadrant, once every three (3) years.
29. Osseous grafts—only autogenous grafts are covered. Synthetic grafting techniques are not covered.

30. Pedicle grafts.
31. Free soft tissue grafts.
32. Sedative Fillings.

**D. Type IV: Major Dental Services**

A twelve (12) month waiting period applies to Bridges, Dentures, Crowns, and Dental Implants for all new Enrollees. The waiting period shall be waived for all accidental injuries, not just those involving chewing or biting.

Benefits for the services listed below include an allowance for all temporary restorations and appliances and for one (1) year follow-up care:

1. Synthetic bone grafting procedures.
2. Recement inlays; recement crowns; recement bridges.
3 Crown build-up—covered only for endodontically treated teeth that require crowns and only if Medically Necessary and covered once in a twenty-four month period.
4. Tissue conditioning—limited to repairs or adjustments performed more than twelve (12) months after the initial insertion of prosthesis.
5. Repairs to full dentures, repairs to partial dentures, and/or repairs to bridges—limited to repairs performed more than twelve (12) months after the initial insertion of prosthesis.
6. Repairs to crowns.
7. Inlays and onlays—covered only when the teeth cannot be restored by a filling, and only if more than seven (7) years have elapsed since the last placement. If a tooth can be restored with a filling, the benefit will be limited to the allowable benefit for an amalgam or composite restoration.
8. Crowns and laminate veneers—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures, or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident or erosion. Coverage is allowed if more than seven (7) years have elapsed since the last placement. For Insureds under age sixteen (16), benefits are limited to plastic/resin-based or stainless steel crowns.
9. Stainless steel crowns—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures, or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident or erosion. Coverage is allowed if more than seven (7) years have elapsed since the last placement.
10. Post and core.
11. Full dentures—includes all adjustments within six (6) months of installation. Replacement of a denture is covered only if the existing denture is more than seven (7) years old and cannot be repaired. There are no additional benefits for overdentures or customized dentures.
12. Partial dentures—includes two (2) clasps and rests, all teeth, and all adjustments within six (6) months of installation. Replacement of a partial denture with another denture or fixed bridgework is eligible for benefits only if the existing denture is more than seven (7) years old and cannot be repaired. There are no additional benefits for precision or semi-precision attachments.
13. Each additional clasp and rest (beyond two (2)).
14. Denture adjustments—one (1) adjustment per Benefit Period and only if performed more than six (6) months after the insertion of the denture.
15. Relining dentures—initial placement of dentures—may be relined once within six (6) months of insertion. Subsequent relines must be performed twelve (12) months after initial placement and no more than once in a twenty-four (24) month period.
16. Fixed bridges—upgrading from a partial denture to fixed bridgework is covered only if the patient's arch cannot be adequately restored with a partial denture. Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than seven (7) years old and cannot be repaired.
17. Implants, including the implant body, implant abutment and implant crown – lifetime benefit limit of nine hundred dollars ($900) per tooth, per insured.

Implant body—limited to once per tooth, per Lifetime. Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.

Implant abutment—limited to once per tooth, per Lifetime. Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.

Implant Crown – Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.

**E. Type V: Orthodontic Services**

A twelve (12) month waiting period applies for all Orthodontic Services for new Enrollees

1. Orthodontia or Orthodontic Treatment.

## ELIGIBILITY AND ENROLLMENT SECTION

**I. Eligibility and Enrollment**

All Eligible Employees will have the opportunity to apply for coverage under this Policy. All applications submitted to Blue Cross of Idaho (BCI) by the Group now or in the future, shall be for Eligible Employees or Eligible Dependents only. Once enrolled under the Policy, Eligible Employees may not change to another Policy until an Open Enrollment Period.

**A. Eligible Employee**

Eligible Employees who are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week and whose term of employment is expected to exceed five (5) continuous months.

Employees hired on or after the effective date of this Policy will have coverage for him or herself and their Dependent(s) effective the first day of the month following ninety (90) days of employment, provided enrollment is completed within thirty (30) days of the date of hire. The following exceptions apply: Benefits for employees *rehired* within twelve (12) months of the last date of employment with the state and who were eligible for benefits on date of termination will be effective on the first day of the month following the date of rehire, provided enrollment is completed within (30) days of rehire date. Eligible Employees who remain employed but lose coverage due to a reduction in hours or who choose not to self-pay during periods of leave without pay will have their coverage resume the first day of the month following the date they return to eligibility or active status, provided a new enrollment form is completed within thirty (30) days of the date they return to benefit-eligible status.

**B. Eligible Dependent**

1. Eligible Dependent means: (1) The spouse of the Enrollee and/or (2) the unmarried children of an Enrollee or Enrollee's spouse, up to their 21st birthdays. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time placed with the Enrollee. The term "children" also includes children legally dependent upon the Enrollee or Enrollee's spouse for support where a normal parent-child relationship exists with the expectation that the Enrollee will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with the Enrollee, a parent-child relationship shall not be deemed to exist even though the Enrollee or the Enrollee's spouse provides support. Such children may be covered beyond their 21st birthdays so long as they are unmarried and are eligible to be claimed as dependents on the Enrollee's most recent U.S. Individual Income Tax return, but not beyond the end of the calendar month in which they attain age twenty-five (25).

**C. Conditions**

1. An Eligible Employee's spouse may not enroll in this plan if said spouse is an Eligible Employee of the Group and enrolled in any other Health Benefit Plan offered by the Group.
2. Under special circumstances approved by the Group, other children under the custodial care of the Enrollee may be considered as Eligible Dependent(s).
3. If both parents are Eligible Employees of the Group and enrolled in any Health Benefit Plan offered by the Group, eligible dependent children may be enrolled under one or the other parent's policy, but not both.
4. An Enrollee must notify BCI and/or within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility status took place.

**II. Group Contribution**

If applicable, the Group agrees to pay the appropriate percentage of the premium for each enrolled Insured, as determined through legislative appropriations. The employee shall authorize the Group to withhold, deduct or collect the monthly payment and remit such payments to BCI in accordance with the application form submitted by each employee. In the event of COBRA, Leave of Absence Without Pay, or other circumstances, the Enrollee may be required to pay the entire premium.

**III. Miscellaneous Eligibility and Enrollment Provisions**

**A.** The Group agrees to collect required Enrollee payments through payroll withholding and be responsible for making the required payments to BCI. If, during the Benefit Period, the Group offers to its employees any other hospital, medical, or surgical coverage that is available to the Group from BCI, but not provided by or through BCI, including but not limited to, coverage under a fee for service/indemnity plan, managed care organization or other similar program or plan, BCI, at its sole option and upon thirty (30) days written notice to the Group, may recalculate the required premiums for the Group's Insureds. Thereafter, the Group must timely pay the recalculated premiums to maintain coverage under this Policy.

**B.** Before the effective date of the change, the Group shall submit all eligibility changes for Enrollees and Eligible Dependents on a BCI approved form (electronic application, e-mail, etc.).

**C.** For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage under this Policy (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee, as the case may be, must complete a BCI application and submit it through the Group to BCI.

**D.** Except as provided otherwise in this section and after completion of any applicable eligibility waiting period as determined by the Group, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent will be the first day of the month following the month of enrollment.

**E.** The Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee's application is the Group's Policy Date if the application is submitted to BCI by the Group on or before the Policy Date. Employees hired on or after the effective date of this Policy will have coverage for him or herself and their Dependents effective the first day of the month following date of hire, provided enrollment is completed within thirty (30) days of the date of hire.

**F.** A disabled Enrolled Eligible Employee shall be able to maintain his or her coverage up to thirty (30) months following the date of disability upon payment of appropriate premium.

**G.** 1. Except as provided otherwise in subparagraphs G2. and G3. below, the initial enrollment period is thirty (30) days for Eligible Employee and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Policy.

2. The initial enrollment period is sixty (60) days for an Eligible Dependent who is an Enrollee's newborn natural child, or child who is adopted by the Enrollee, or placed for adoption with the Enrollee before age eighteen (18). An Enrollee's newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child's date of birth, are covered under this Policy from and after the date of birth for 60 days.

In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application and submit the required premium within thirty-one (31) days of the date monthly billing is received by the Group and a notice of premium is provided to the Enrollee by the Group.

The Effective Date of coverage will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child's date of birth, provided the child is enrolled during the applicable initial enrollment period.

If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Policy, 'child' means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Policy, "placed for adoption" means physical placement in the care of the adoptive

Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. The initial enrollment period is sixty (60) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage will be the first day of the month following the date of marriage.

**H. Late Enrollee**

If an Eligible Employee or an Eligible Dependent does not enroll during the applicable initial enrollment period described in Paragraph G. of this section, the Eligible Employee or Eligible Dependent is a Late Enrollee. The Effective Date of coverage for a Late Enrollee will be the first day of the month following the receipt and acceptance of a completed enrollment application or ninety (90) days of employment, whichever is less.

**G. Special Enrollment Periods**

An Eligible Employee or Eligible Dependent will not be considered a Late Enrollee if:

1. The Eligible Employee or Eligible Dependent meets each of the following:
   a) The individual was covered under Qualifying Previous Coverage at the time of the initial enrollment period.
   b) The individual lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage.
   c) The individual requests enrollment within thirty (30) days after termination of the Qualifying Previous Coverage.
2. The individual is employed by an employer that offers multiple Health Benefit Plans and the individual elects a different plan during an open enrollment period.
3. A court has issued a court order requiring that coverage be provided for an Eligible Dependent by an Enrollee under this Policy, and application for enrollment is made within thirty (30) days after issuance of the court order.
4. The individual first becomes eligible.
5. The Eligible Employee and/or Eligible Dependent become eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP) and coverage under this Policy is requested no later than 60 days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.
6. Coverage under Medicaid or CHIP for an Eligible Employee and/or Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested under this Policy no later than 60 days after the date of termination of such coverage.

## IV. Qualified Medical Child Support Order

**A.** If this Policy provides for family coverage, BCI will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a child of an Enrollee under this Policy or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Policy, or
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

**B.** A medical child support order meets the requirements of a QMCSO if such order clearly specifies:

1. The name and the last known mailing address (if any) of the Enrollee and the name and mailing address of each child covered by the order.
2. A reasonable description of the type of coverage to be provided by this Policy to each such child, or the manner in which such type of coverage is to be determined.
3. The period to which such order applies.

**C.** Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order, the group administrator and each affected child of the receipt and of the criteria by which BCI determines if the medical child support order is a QMCSO. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.

**D.** BCI will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian, or the Idaho Department of Health and Welfare.

## DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Policy. Other terms may be defined where they appear in this Policy. All Providers and Facilities listed in this Policy and in the following section must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license in order for BCI to provide benefits. Definitions in this Policy shall control over any other definition or interpretation unless the context clearly indicates otherwise.

**Accidental Injury**—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without an Insured's foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

**Adverse Benefit Determination**—any denial, reduction or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under this Policy.

**Benefit Period**— the period of time from July 1 to June 30 of the following year, unless otherwise noted, during which an Insured accumulates annual benefit limits, Deductible amounts and Out-of-pocket Limits and may receive Covered Services.

**Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho or BCI)**—a nonprofit mutual insurance company.

**Benefits After Termination—**the benefits, if any, remaining under this Policy after a person ceases to be an Insured.

**Closed List of Dental Covered Services—**the list of Covered Dental Services in the Dental Benefits Section for which benefits are available under this Policy.

**Coinsurance**—the percentage of the Maximum Allowance or the actual charge, whichever is less, an Insured is responsible to pay Out-of-pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

**Congenital Anomaly**— a condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In this Policy, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

**Contracting Dentist**—a Dentist who has entered into a written agreement with BCI regarding payment for Dental Covered Services rendered to an Insured. If a dentist has an agreement for claims payment with an affiliate in the area where the Covered Services are rendered, BCI will base the payment on the local plan's payment arrangement and allow in-network benefits.

**Cost Effective–** A requested or provided medical service or supply that is Medically Necessary in order to identify or treat an Insured's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Insured's clinical condition and the Covered Provider's expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.
2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Insured's condition, Disease, Illness or injury.

**Copayment**—a designated dollar and/or percentage amount, separate from Coinsurance, that an Insured is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

**Covered Provider**—a Provider specified in this Policy from whom an Insured must receive Covered Services in order to be eligible to receive benefits.

**Covered Services**—services listed in the Closed List of Dental Covered Services.

**Deductible**—the amount an Insured is responsible to pay Out-of-pocket before BCI begins to pay benefits for Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

**Dental Consultant—**a duly licensed dentist retained by BCI for the purpose of advising and performing any and all services requested in connection with review of dental claims, as well as consulting and advising in the area of dentistry.

**Dental Hygienist**—a person licensed to practice dental hygiene who is acting under the supervision and direction of a Dentist. For BCI to provide benefits, the Dental Hygienist must be licensed in the state where service is rendered and the hygienist must be performing within the scope of his/her license.

**Dental Treatment Plan**—the Dentist's report of recommended treatment on a form satisfactory to BCI that:

1. Itemizes dental procedures necessary for the care of an Insured.
2. Lists the charges for each procedure.
3. Is accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials reasonably required by BCI.

**Dentist**—an individual licensed to practice Dentistry.

**Dentistry or Dental Treatment**—the treatment of teeth and supporting structures, including but not limited to, the replacement of teeth.

**Denturist**—a person licensed in the state where service is rendered to engage in the practice of denturism. For BCI to provide benefits, the Denturist must be performing within the scope of his/her license.

**Disease**—any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without an Insured's awareness of it, and can be of known or unknown cause(s).

**Effective Date**—the date when coverage for an Insured begins under this Policy.

**Eligible Dependent**—(1) the spouse of the Enrollee and/or (2) the unmarried children of an Enrollee or Enrollee's spouse, up to their 21st birthdays. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time placed with the Enrollee. The term "children" also includes children legally dependent upon the Enrollee or Enrollee's spouse for support where a normal parent-child relationship exists with the expectation that the Enrollee will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with the Enrollee, a parent-child relationship shall not be deemed to exist even though the Enrollee or the Enrollee's spouse provides support. Such children may be covered beyond their 21st birthdays so long as they are unmarried and are eligible to be claimed as dependents on the Enrollee's most recent U.S. Individual Income Tax return, but not beyond the end of the calendar month in which they attain age twenty-five (25).

**Eligible Employee—** employees who are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week, or eighty-four (84) hours per month, and whose term of employment is expected to exceed five (5) months in any consecutive twelve (12) month period. Employees hired on or after the effective date of this Policy will have coverage for him or herself and their Dependents effective the first day of the month following date of hire, provided enrollment is completed within thirty (30) days of the date of hire.

**Enrollee**—an Eligible Employee who has enrolled for coverage and has satisfied the requirements of the Eligibility and Enrollment Section.

**Enrollment Date**—the date of enrollment of an Eligible Employee or Eligible Dependent under this Policy, or if earlier, the first day of the probationary period for such enrollment.

**Family Coverage**—the enrollment of an Enrollee and two (2) or more Eligible Dependents under this Policy.

**Group**— the State of Idaho as represented by the Department of Administration.

**Illness**—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without an Insured's awareness of it, and can be of known or unknown cause(s).

**Implant**—a device specifically designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement.

**In-Network Services—**Covered Services provided by a Contracting Dentist.

**Inpatient**—an Insured who is admitted as a bed patient in a Licensed General Hospital or other Facility Provider and for whom a room and board charge is made.

**Insured**—an Enrollee or an enrolled Eligible Dependent covered under this Policy.

**Investigational—**the use of any treatment, procedure, facility, equipment, drug, device or supply that:

1. Is not yet generally recognized by Dentists practicing within the state of Idaho as accepted dental practice, or
2. Requires federal or other governmental approval, for other than Investigational purposes, and such approval has not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply is used.

**Large Employer—**any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least 50% of its working days during the preceding calendar year, employed no less than fifty-one (51) Eligible Employees, the majority of whom were employed within this state. In determining the number of Eligible Employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

**Maximum Allowance**— for Covered Services under the terms of this Policy, Maximum Allowance is the lesser of the billed charge or the amount established by BCI as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Noncontracting or Contracting Dentist with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

Maximum Allowance for Covered Services provided by Contracting or Noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by Contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

**Medically Necessary (or Medical Necessity)–** The Covered Service or supply recommended by the treating Covered Provider to identify or treat an Insured's condition, Disease, Illness or Accidental Injury and which is determined by BCI to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Insured.
2. Proven to be effective in improving health outcomes;
   a. For new treatment, effectiveness is determined by peer reviewed scientific evidence;
   b. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Insured or Covered Provider.
4. Cost Effective for this condition.

The fact that a Covered Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Policy.

The term Medically Necessary as defined and used in this Policy is strictly limited to the application and interpretation of this Policy, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

**Noncontracting Dentist**—a Dentist who has not entered into a written agreement with BCI regarding payment for Dental Covered Services rendered to an Insured. If the Dentist does not have an agreement for r claims payment with the affiliate in the area where Covered Services are rendered, BCI will base the payment on the Maximum Allowance and allow Out-of-Network benefits.

**Orthodontia or Orthodontic Treatment**—the movement of teeth through bone by means of active orthodontic appliances in order to correct a patient's malocclusion (misalignment of the teeth).

**Out-Of-Network Services—**Covered Services that are not rendered by a Contracting Dentist.

**Policy**—this Policy, which includes only the Benefits Outline, Group application, individual enrollment applications, Insured identification cards, any written endorsements, riders, amendments, or any other written agreements between BCI and the Group executed by an authorized officer of BCI.

**Policy Date**—the date specified in this Policy on which coverage commences for the Group (July 1).

**Post-Service Claim**—any claim for a benefit under this Policy that does not require prior authorization before services are rendered.

**Pre-Service Claim**—any claim for a benefit under this Policy that requires prior authorization before services are rendered.

**Provider—**a Dentist, Dental Hygienist or Denturist who provides services under this Policy and is acting within the scope of his or her license.

**Qualifying Previous And Qualifying Existing Coverage**—"Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following;

1. Group health benefit plan;
2. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market or otherwise;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid);
5. Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents). For purposes of 55 Title 10, United States Code, "uniformed services" means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service;
6. A medical care program of the Indian Health Services or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP)); \
9. A public health plan, which for purposes of this act, means a plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan; or
10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. 2504 (e)).

A State Children's Health Insurance Program (CHIP), under Title XXI of the Social Security Act, is creditable coverage, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

CMS Insurance Standards Bulletin, Transmittal No. 05-01 clarified that:

"Any public health plan, including a plan established or maintained by the U. S. government, or a foreign country, is creditable coverage for purposes of identifying eligible individuals under Part B of Title XXVII of the Public Health Service Act (PHS Act)".

**Single Coverage**—the enrollment of only the Enrollee under this Policy.

**Sound Natural Tooth** —for avulsion or traumatic tooth loss, a Sound Natural Tooth is considered to be one in which the existing conditions of the tooth and its supporting structures did not influence the outcome of the Injury in question, is without impairment, including but not limited to periodontal or other conditions, and is not in need of the treatment provided for any reason other than the Accidental Injury.

For injuries related to fracture of the coronal surface, a Sound Natural Tooth is considered to be one which has not been restored by, including but not limited to, a crown, inlay, onlay or porcelain restoration, or treated by endodontics.

**Surgery**—within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures using specialized instruments.
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

**Totally Disabled (or Total Disability)**—as certified in writing by an attending Physician, a condition resulting from Disease, Illness or Accidental Injury causing:

1. An Enrollee's inability to perform the principal duties of the regular employment or occupation for which the Enrollee is or becomes qualified through education, training, or experience; and the Enrollee is not in fact engaged in any work profession, or avocation for fees, gain, or profit; or
2. An enrolled Eligible Dependent to be so disabled and impaired as to be unable to engage in the normal activities of an individual of the same age and gender.

**Two-Party Coverage**—the enrollment of the Enrollee and one (1) Eligible Dependent under this Policy.

## EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Policy, the following exclusions and limitations apply to the entire Policy, unless otherwise specified.

**I. General Exclusions And Limitations**

There are no benefits for services, supplies, drugs or other charges that are:

**A.** Procedures that are not included in the Closed List of Dental Covered Services; or that are not Medically Necessary for the care of an Insured's covered dental condition; or that do not have uniform professional endorsement.

**B.** Charges for services that were started prior to the Insured's Effective Date. The following guidelines will be used to determine the date when a service is deemed to have been started:

1. For full dentures or partial dentures: on the date the final impression is taken.
2. For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared.
3. For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex.
4. For periodontal Surgery: on the date the Surgery is actually performed.
5. For all other services: on the date the service is performed.
6. For orthodontic services, if benefits are available under this Policy: on the date any bands or other appliances are first inserted.

**C.** Cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgam or composite fillings).

**D.** Replacement of an existing crown, inlay or onlay that was installed within the preceding seven (7) years or replacement of an existing crown, inlay or onlay that can be repaired.

**E.** Appliances, restorations or other services provided or performed solely to change, maintain or restore vertical dimension or occlusion.

**F.** A service for cosmetic purposes, unless necessitated as a result of Accidental Injuries received while the Insured was covered by BCI.

**G.** In excess of the Maximum Allowance.

**H.** A partial or full removable denture for fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding seven (7) years.

**I.** Orthodontic services and supplies unless otherwise specifically listed in the Closed List of Dental Covered Services.

**J.** Replacement of lost or stolen appliances.

**K.** Ridge augmentation procedures.

**L.** Any procedure, service or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla or mandible for a prosthetic appliance. Excluded services include, but are not limited to, vestibuloplasty, stomatoplasty and bone grafts (either synthetic or autogenous) to the alveolars, maxilla or mandible.

**M.** Any procedure, service or supply required directly or indirectly to treat a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.

**N.** Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.

**O.** Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable.

**P.** Any service, procedure or supply for which the prognosis for success is not reasonably favorable as determined by BCI.

**Q.** Myofunctional therapy and biofeedback procedures.

**R.** For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures.

**S.** Diagnostic casts.

**T.** Occlusal adjustments.

**U.** Not prescribed by or upon the direction of a Provider.

**V.** Investigational in nature;

**W.** Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party.

**X.** Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefor would vary, or are or would be affected by the existence of coverage under this Policy; or

**Y.** Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

**Z.** Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.

**AA.** Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

**AB.** For personal hygiene, comfort, beautification or convenience items even if prescribed by a Dentist, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs.

**AC.** For telephone consultations; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Dentist or other Provider.

**AD.** For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child..

**AE.** For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

**AF.** For treatment or other health care of any Insured in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Insured to Covered Services under this Policy, if and to the extent those benefits are payable to or due the Insured under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's or other similar policy of insurance, contract or underwriting plan;

In the event Blue Cross of Idaho for any reason makes payment for or otherwise provides benefits excluded by this provision, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Insured, and the Insured's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Insured or his or her estate for such services, supplies, drugs or other charges so provided by Blue Cross of Idaho in connection with such Illness, Disease, Accidental Injury or other condition.

**AG.** Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.

**AH.** Provided to persons who were enrolled as Eligible Dependents after they cease to qualify as Eligible Dependents due to a change in Eligibility status which occurs during the Policy term.

**AI.** Provided outside the United States, which if had been provided in the United States, would not be Covered Services under this Policy.

**AJ.** Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

**AK.** For acupuncture or hypnosis.

**AL.** Pulp caps.

**AM.** Tooth transplantation.

**AN.** Nitrous oxide.

**AO.** Repair, removal, cleansing or reinsertion of Implants.

**AP.** Precision or semi-precision attachments (including Implants placed to support a fixed or removable denture).

**AQ.** Denture duplication.

**AR.** Oral hygiene instruction.

**AS.** Treatment of jaw fractures.

**AT.** Charges for acid etching.

**AU.** Charges for oral cancer screening which are included in a regular oral examination.

**AV.** Periodontal splinting procedures.

## II. Conditions

### A. Right to Review Dental Work

Before providing benefits for Covered Services, Blue Cross of Idaho has the right to refer the Insured to a Dentist of its choice and at its expense to verify the need, quantity and quality of dental work claimed as a benefit under this section.

### B. Care Rendered by More Than One Dentist

If an Insured transfers from the care of one Dentist to another Dentist during a Dental Treatment Plan, or if more than one Dentist renders services for one dental procedure, Blue Cross of Idaho will pay no more than the amount that it would have paid had but one Dentist rendered the service.

### C. Alternate Treatment Plan

If a Dentist and an Insured select a Dental Treatment Plan other than that which is customarily provided by the dental profession, payments of benefits available under this section shall be limited to the Dental Treatment Plan that is the standard and most economical, according to generally accepted dental practices.

## GENERAL PROVISIONS SECTION

**I. Entire Policy—Changes**

This Policy, which includes only the Benefits Outline, individual enrollment applications, Insured identification cards, and any written endorsements, riders, amendments, or other written agreements approved in writing by an authorized Blue Cross of Idaho (BCI) officer and the State of Idaho Group), is the entire Policy between the Group and BCI. No agent or representative of BCI, other than a BCI officer, may change this Policy or waive any of its provisions. This Policy supplants and replaces any and all previous oral or written agreements, certificates, contracts, policies or representations, which shall have no further force and effect.

**II. Records of Insured Eligibility and Changes in Insured Eligibility**

**A.** The Group shall furnish completed applications or other BCI approved forms required by BCI for it to provide coverage of the Group's Insureds under this Policy. In addition, the Group will provide written notification to BCI within thirty (30) days of the Effective Date of any changes in an Insured's enrollment and benefit coverage status under this Policy.

**B.** A notification by the Group to BCI must be furnished on BCI approved forms, and according to rules and regulations of BCI. The notification must include all information reasonably required by BCI to effect changes, and must be accompanied by payment of applicable premiums.

**III. Termination or Modification of This Policy**

**A.** The Group or BCI may unilaterally terminate or modify the terms of this Policy as required by statutory and/or regulatory changes. Such termination or modification shall be effective immediately or as required by the statutory or regulatory change. BCI shall give the Group written notice of such modification or termination.

**B.** This Policy may be unilaterally terminated by BCI for any of the following:

1. For the Group's fraud or intentional misrepresentation of a material fact.
2. If BCI elects not to renew all of its Health Benefit Plans delivered or issued for delivery to Large Employers in the state of Idaho. In which case, BCI will provide notice to the Group and its Insureds of such nonrenewal at least one hundred eighty (180) days in advance of the date of nonrenewal.

**C.** If the Group fails to pay premiums as agreed in the Eligibility and Enrollment Section, this Policy will terminate without notice at the end of the period for which the last premiums were paid. However, if the Group makes premium payments within sixty (60) days after the due date, BCI will reinstate this Policy as of the due date. No benefits are available during this sixty (60) day period unless all premiums are properly paid before expiration of the sixty (60)day period. BCI reserves the right to apply a twelve percent (12%) annualized interest fee on any portion of the balance owed by the Group to BCI that remains unpaid thirty (30) days or more beyond the original due date.

**D.** No more than 120 days prior to the date of annual renewal, BCI must provide to the Group a written proposal of renewal rates for the then current benefit plan.

**IV. Termination Or Modification of An Insured's Coverage Under This Policy**

**A.** If an Enrollee ceases to be an Eligible Employee or the Group does not remit the required premium, the Enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made.

**B.** Except as provided in this paragraph, coverage under this Policy will terminate on the date an Insured no longer qualifies as an Insured, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for an Insured who is an unmarried dependent child incapable of self-sustaining employment by reason of mental handicap or retardation or physical handicap, who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Enrollee for support and maintenance, provided the Enrollee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to BCI (at the Enrollee's expense) a Physician's certification of such dependent child's incapacity. BCI may require, at reasonable intervals during the two (2) years following when the child reaches the age limit, subsequent proof of the child's continuing disability and dependency. After two (2) years, BCI may require such subsequent proof once each year. Coverage for the dependent child will continue so long as this

Policy remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

**C.** Termination or modification of this Policy automatically terminates or modifies all of the Insured's coverage and rights hereunder. It is the responsibility of the Group to notify all of its Insureds of the termination or any modification of this Policy, and BCI's notice to the Group, upon mailing or any other delivery, constitutes complete and conclusive notice to the Insureds.

**D.** Except as otherwise provided in this Policy, no benefits are available to an Insured for Covered Services rendered after the date of termination of an Insured's coverage.

**E.** Prior to legal finalization of an adoption, the coverage provided in this Policy for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee until the first of the following events occurs:

1. The date the child is removed permanently from placement and the legal obligation terminates, or
2. The date the Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

If one (1) of the foregoing events occurs, coverage terminates on the last day of the month in which such event occurs.

**F.** Coverage under this Policy will terminate for an Eligible Dependent on the last day of the month he or she no longer qualifies as an Eligible Dependent due to a change in eligibility status.

## V. Benefits After Termination of Coverage

**A.** When this Policy remains in effect but an Insured's coverage terminates for reasons other than those specified in General Provisions IV.E., benefits will be continued:

1. If the Insured is eligible for and properly elects continuation coverage in accordance with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto.

   Most employers who employ twenty (20) or more people on a typical business day are subject to COBRA. If the Group is subject to COBRA, an Insured may be entitled to continuation coverage. Insureds should check with the Group for details.
2. For Covered Services of an Insured who is being treated as an Inpatient on the day the Insured's coverage terminates, but only until the Insured is discharged, or the end of the Benefit Period in which coverage terminated, or until benefits are exhausted, whichever occurs first. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the Inpatient confinement.

**B.** When the Group or BCI terminates this Policy, benefits will be continued:

1. For Covered Services of an Insured who is being treated as an Inpatient on the day the Insured's coverage terminates, but only until the Insured is discharged, or the end of the Benefit Period in which coverage terminated, or until benefits are exhausted, whichever occurs first. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the Inpatient confinement.
2. For Covered Services directly related to a pregnancy that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more than twelve (12) consecutive months following the date coverage terminates or until the conclusion of the pregnancy, or until replacement coverage is in effect according to General Provisions section XXIX. of this Policy, whichever occurs first.
3. For Covered Services directly related to a Total Disability that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more than twelve (12) consecutive months following the date coverage terminates or until the Total Disability ceases, whichever occurs first.

**VI. Transfer Privilege**

An Insured is eligible to transfer his or her dental care coverage to a BCI individual policy if the Insured ceases to be eligible for coverage under this Policy. If an Insured's enrollment status changes as indicated below, the following Insureds may apply for transfer:

**A.** The Enrollee, if the Enrollee ceases to be an Eligible Employee as specified in the Eligibility and Enrollment Section. The Enrollee may include enrolled Eligible Dependents in the Enrollee's application for transfer.

**B.** An enrolled dependent child who ceases to be an Eligible Dependent as specified in the Eligibility and Enrollment Section.

**C.** The Enrollee's spouse (if an Insured) upon entry of a final decree of divorce or annulment.

**D.** The Enrollee's enrolled Eligible Dependents upon the Enrollee's death.

To apply for a transfer, the Insured must submit a completed application and the appropriate premium to BCI within thirty (30) days after the loss of eligibility of coverage. If approved, benefits under the new policy are subject to the rates, regulations, terms, and provisions of the new policy.

If the Group or BCI terminates this Policy, and the Group provides another dental care plan to its employees effective immediately after the termination of this Policy, no Insured will be entitled to this transfer privilege.

**VII. Contract Between BCI and the Group—Description Of Coverage**

This Policy is a contract between BCI and the Group. BCI will provide the Group with a copyof the Policy. This Policy shall not be construed as a contract between BCI and any Enrollee. BCI's mailing or other delivery of this Policy to the Group constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

**VIII. Applicable Law**

This Policy shall be governed by and interpreted according to the laws of the state of Idaho. BCI and the Group consent to the jurisdiction of the state courts of Ada County in the state of Idaho in the event of any dispute between them. The rights of the Insureds and coverage under this Policy may be affected by applicable state and federal laws, including without limitation the Health Insurance Portability and Accountability Act.

**IX. Notice**

Any notice required under this Policy must be in writing. BCI's notices to the Group will be sent to the Group's address as it appears on BCI's records, and mailing or delivery to the Group constitutes complete and conclusive notice to the Insureds. Notice given to BCI must be sent to BCI's address contained in the Group Application. The Group shall give BCI immediate written notice of any change of address for the Group or any of its Insureds. BCI shall give the Group immediate written notice of any change in BCI's address. When BCI is required to give advice or notice, the depositing of such advice or notice with the U.S. Postal Service, regular mail, or the other delivery conclusively constitutes the giving of such advice or notice on the date of such mailing or delivery.

**X. Benefits to Which Insureds are Entitled**

**A.** Subject to all of the terms of this Policy, an Insured is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.

**B.** Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Covered Provider.

**C.** Benefits for Covered Services specified in this Policy are provided only for Covered Services that are rendered by the Covered Providers specified in the benefits sections of this Policy and that are regularly and customarily included in such Covered Providers' charges.

**D.** Covered Services are subject to the availability of Providers and the ability of the employees of such Providers to provide such services. BCI shall not assume nor have any liability for conditions beyond its control that affect the Insured's ability to obtain Covered Services.

**XI. Notice of Claim**

BCI is not liable under this Policy to provide benefits unless a proper claim is furnished to BCI that shows Covered Services have been rendered to an Insured. A claim must be provided within one (1) year from the date a Covered Service is rendered. The claim must include all the data necessary for BCI to determine benefits.

**XII. Release and Disclosure of Medical Records and Other Information**

In order to effectively apply the provisions of this Policy, BCI may obtain information from Providers and other entities pertaining to any health related services that the Insured may receive or may have received in the past. BCI may also disclose to Providers and other entities, information obtained from the Insured's transactions such as policy coverage, premiums, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Insured's privacy, BCI treats all information in a confidential manner. For further information regarding BCI's privacy policies and procedures, the Insured may request a copy of BCI's Notice of Privacy Practices by contacting customer service at the number provided in this Policy.

Each Insured also authorizes disclosures to the employer, association, trust fund, union, or similar entity to which this Policy is issued for purposes of utilization review or audit and such other disclosures as may be permitted or required by law.

**XIII. Exclusion Of General Damages**

Liability under this Policy for benefits conferred hereunder, including recovery under any claim or breach of this Policy, is limited to the actual benefits for Covered Services as provided herein and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

**XIV. Payment of Benefits**

**A.** The Insured authorizes BCI to make payments directly to Providers rendering Covered Services to the Insured for benefits provided under this Policy. Notwithstanding this authorization, BCI reserves and has the right to make such payments directly to the Insured. Except as provided by law, BCI's right to pay an Insured directly is not assignable by an Insured nor can it be waived without BCI's concurrence nor may the right to receive benefits for Covered Services under this Policy be transferred or assigned, either before or after Covered Services are rendered.

**B.** Once Covered Services are rendered by a Provider, BCI is not obligated to honor Insured requests not to pay claims submitted by such Provider, and BCI shall have no liability to any person because of its rejection of such request. However, for good cause and in its sole discretion, BCI may nonetheless deny all or any part of any Provider claim.

**XV. Insured/Provider Relationship**

**A.** The choice of a Provider is solely the Insured's.

**B.** BCI does not render Covered Services but only makes payment for Covered Services received by Insureds. BCI is not liable for any act or omission or for the level of competence of any Provider, and BCI has no responsibility for a Provider's failure or refusal to render Covered Services to an Insured.

**C.** The use or nonuse of an adjective such as Contracting or Noncontracting is not a statement as to the ability of the Provider.

**XVI. Participating Plan**

BCI may, in its sole discretion, make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Insureds, but it shall have no obligation to do so.

**XVII. Coordination of This Policy's Benefits With Other Benefits**

This Coordination of Benefits (COB) provision applies when an Insured has health care coverage under more than one (1) Contract. Contract is defined below.

The Order of Benefit Determination Rules govern the order in which each Contract will pay a claim for benefits. The Contract that pays first is called the Primary Contract. The Primary Contract must pay benefits in accordance with its policy terms without regard to the possibility that another Contract may cover some expenses. The Contract that pays

after the Primary Contract is the Secondary Contract. The Secondary Contract may reduce the benefits it pays so that payments from all Contracts does not exceed one hundred percent (100%) of the total Allowable Expenses.

**A. Definitions**

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no COB among those separate contracts.
   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   b) Contract does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

   Each Contract for coverage under a) or b) is a separate Contract. If a Contract has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate Contract.

2. This Contract means, in a COB provision, the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Contracts. Any other part of the Contract providing health care benefits is separate from this plan. A Contract may apply one (1) COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, any may apply under COB provision to coordinate other benefits.

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Insured has health care coverage under more than one (1)Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract's benefits. When This Contract is secondary, it determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

4. Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Contract covering the Insured. When a Contract provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Contract covering the Insured is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:
   a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Contracts provides coverage for private hospital room expenses.

   b) If an Insured is covered by two ( 2) or more Contracts that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   c) If an Insured is covered by two (2) or more Contracts that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees it not an Allowable Expense.

d) If an Insured is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits or services on the basis of negotiated fees, the Primary Contract's payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

e) The amount of any benefit reduction by the Primary Contract because a covered person has failed to comply with the Contract provisions is not an Allowable Expense. Examples of these types of Contract provisions include second surgical opinions, pre-certificate of admissions, and preferred provider arrangements.

5. Closed Panel Plan is a Contract that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Group, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

**B. Order Of Benefit Determination Rules**

When an Insured is covered by two (2) or more Contracts, the rules for determining the order of benefit payments are as follows:

1. The Primary Contract pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Contract.

2. a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Contracts state that the complying Contract is primary.

b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Contract provided by the Contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

3. A Contract may consider the benefits paid or provided by another Contract in calculating payment of its benefits only when it is secondary to that other Contract.

4. Each Contract determines its order of benefits using the first of the following rules that apply:
   a) Non-Dependent or Dependent. The Contract that covers the Insured other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Contract and the Contract that covers the Insured as a dependent is the Secondary Contract. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Insured as a dependent; and primary to the Contract covering the Insured as other than a dependent (e.g. a retired employee); then the order of benefits between the two Contracts is reversed so that the Contract covering the Insured as an employee, member, policyholder, subscriber or retiree is the Secondary Contract and the other Contract is the Primary Contract.

b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or If both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies toContract year commencing after the Contract is given notice of the court decree;

ii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Contract covering the Custodial Parent;
2. The Contract covering the spouse of the Custodial Parent;
3. The Contract covering the non-Custodial Parent; and then
4. The Contract covering the spouse of the non-Custodial Parent.

For a dependent child covered under more than one Contract of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c) Active Employee or Retired or Laid-off Employee. The Contract that covers an Insured as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Insured as a retired or laid-off employee is the Secondary Contract. The same would hold true if an Insured is a dependent of an active employee and that same Insured is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

d) COBRA or State Continuation Coverage. If an Insured whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Contract, the Contract covering the Insured as an employee, member, subscriber or retiree or covering the Insured as a dependent of an employee, member, subscriber or retiree is the Primary Contract and the COBRA or state or other federal continuation coverage is the Secondary Contract. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

e) Longer or Shorter Length of Coverage. The Contract that covered the Insured as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Insured the shorter period of time is the Secondary Contract.

f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Contracts meeting the definition of Contract. In addition, This Contract will not pay more than it would have paid had it been the Primary Contract.

**C. Effect On The Benefits Of This Contract**

1. When This Contract is secondary, it may reduce its benefits so that the total benefits paid or provided by all Contracts during a Contract year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Contract will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Contract that is unpaid by the Primary Contract. The Secondary Contract may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Contract, the total benefits paid or provided by all Contracts for the claim do not exceed the total Allowable Expenses for that claim. In addition, the Secondary Contract shall credit to its Contract deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

2. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Contract and other Closed Panel Plans.

**D. Facility Of Payment**

A payment made under another Contract may include an amount that should have been paid under This Contract. If it does, BCI may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Contract. BCI will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

**E. Right Of Recovery**

If the amount of the payments made by BCI is more than it should have paid under this COB provision, it may recover the excess from one or more of the Insureds it has paid or for whom it has paid; or any other Insured or organization that may be responsible for the benefits or services provided for the covered Insured. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## XVIII. Indemnity by The Group And Blue Cross Of Idaho

Anything contained in this Policy notwithstanding, including any limitation on damages, the Group and BCI agree to defend, indemnify and hold harmless the other from and against any claim, demand, expense, loss, damage, cost, judgment, fee or liability the other receives, incurs or sustains that is caused by or arises out of any negligent act or omission of the indemnifying party related to this Policy. The indemnification obligation of the Group is subject to the limitations of the Idaho Tort Claims Act, including dollar amounts.

## XIX. Incorporated By Reference

All of the terms, limitations and exclusions of coverage contained in this Policy are incorporated by reference into all sections, endorsements, riders, and amendments and are as effective as if fully expressed in each one unless specifically noted to the contrary.

## XX. Inquiry And Appeals Procedures

**A. Informal Inquiry**

For any initial questions concerning a claim, an Insured should call or write BCI's Customer Services Department. BCI's phone numbers and addresses are listed on the Explanation of Benefits (EOB).

**B. Formal Appeal**

An Insured who wishes to formally appeal a Pre-Service Claim decision by BCI may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed. For non-urgent claim appeals, BCI will mail a written reply to the Insured within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.
3. Furthermore, the Insured or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original, non-urgent claim decision is upheld upon reconsideration, the Insured may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of BCI's mailing of the initial reconsideration decision. The Appeals and Grievance Coordinator will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

**C.** An Insured who wishes to formally appeal a Post-Service Claims decision by BCI may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.
2. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed. BCI shall mail a written reply to the Insured within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.
3. Furthermore, the Insured or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original decision is upheld upon reconsideration, the Insured may send an additional written appeal to the Appeals and Grievance Coordinator requesting *further review*. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of BCI's mailing of the initial reconsideration decision. The Appeals and Grievance Coordinator will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within thirty (30) days of its receipt.

**D. Insured's Rights to an Independent External Review**

***Please read this carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with BCI. If an Insured or their authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final. Except in limited circumstances, the Insured or their authorized representative will have no further right to have the claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.***

If BCI issues a final Adverse Benefit Determination of an Insured's request to provide or pay for a health care service or supply, an Insured may have the right to have BCI's decision reviewed by health care professionals who have no association with BCI. An Insured has this right only if BCI's denial decision involved:

- The Medical Necessity of an Insured's health care service or supply, or
- BCI's determination that an Insured's health care service or supply was Investigational.

An Insured must first exhaust BCI's internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal. Exhaustion of the appeals process is not required if BCI failed to respond to a standard appeal within thirty-five (35) days in writing or to an urgent appeal within three business days of the date the Insured filed the appeal, unless the Insured requested or agreed to a delay. BCI may also agree to waive the exhaustion requirement for an external review request.

An Insured may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St, 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's web site, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

An Insured may act as their own representative in a request or an Insured may name another person, including an Insured's treating health care provider, to act as an authorized representative for a request. If an Insured wants someone else to represent them, an Insured must include a signed "Appointment of an Authorized Representative" form with the request. An Insured's written external review request to the Department of Insurance must include a completed form authorizing the release of any medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without an Insured's completed authorization form. If the request qualifies for external review, BCI's final adverse benefit determination will be reviewed by an independent review organization selected by the Department of Insurance. BCI will pay the costs of the review.

**Standard External Review Request:** An Insured must file a written external review request with the Department of Insurance within four (4) months after the date BCI issues a final notice of denial.

1. Within seven (7) days after the Department of Insurance receives the request, the Department of Insurance will send a copy to BCI.
2. Within fourteen (14) days after BCI receives the request from the Department of Insurance, we will review the request for eligibility. Within five (5) business days after BCI completes that review, we will notify the Insured and the Department of Insurance in writing if the request is eligible or what additional information is needed. If BCI denies the eligibility for review, the Insured may appeal that determination to the Department.
3. If the request is eligible for review, the Department of Insurance will assign an independent review organization to your review within seven (7) days of receipt of BCI's notice. The Department of Insurance will also notify the Insured in writing.
4. Within seven (7) days of the date you receive the Department of Insurance's notice of assignment to an independent review organization, The Insured may submit any additional information in writing to the independent review organization that they want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to the Insured, BCI and to the Department of Insurance within forty-two (42) days after receipt of an external review request.

**Expedited External Review Request:** An Insured may file a written "urgent care request" with the Department of Insurance for an expedited external review of a pre-service or concurrent service denial.

"Urgent care request" means any Pre-Service Claim or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the Insured or the ability of the Insured to regain maximum function;
2. In the opinion of the Covered Provider with knowledge of the covered person's medical condition, would subject the Insured to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The Department of Insurance will send your request to us. BCI will determine, no later than the second ($2^{nd}$) full business day, if the request is eligible for review. BCI will notify the Insured and the Department of Insurance no later than one (1) business day after BCI's decision if the request is eligible. If BCI denies the eligibility for review, the Insured may appeal that determination to the Department of Insurance. If the request is eligible for review, the Department of Insurance will assign an independent review organization to the review upon receipt of BCI's notice. The Department of Insurance will also notify the Insured. The

independent review organization must provide notice of its decision to the Insured, BCI and to the Department of Insurance within seventy-two (72) hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within forty-eight (48) hours of notice of its decision. If the decision reverses BCI's denial, BCI will notify the Insured and the Department of Insurance of the approval of coverage as soon as reasonably practicable, but not later than one (1) business day after making the determination.

**Binding Nature of the External Review Decision:**
If the Group is subject to the federal Employee Retirement Income Security Act (ERISA) laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on BCI. The Insured may have additional review rights provided under federal ERISA laws.

If the Group is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both BCI and the Insured. **This means that if the Insured elects to request external review, the Insured will be bound by the decision of the independent review organization. The Insured will not have any further opportunity for review of BCI's denial after the independent review organization issues its final decision.** If the Insured chooses not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

**XXI. Plan Administrator—COBRA**

BCI is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it. Except for services BCI has agreed to perform regarding COBRA, the Group is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Group.

**XXII. Reimbursement of Benefits Paid by Mistake**

If BCI mistakenly pays benefits on behalf of an Enrollee or his or her Eligible Dependent(s) that the Enrollee or his or her Eligible Dependent(s) is not entitled to under this Policy, the Enrollee must reimburse the erroneous benefits to BCI.

The reimbursement is due and payable as soon as BCI notifies the Enrollee and requests reimbursement. BCI may also recover such erroneous benefits from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, BCI may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though BCI may elect to continue to provide benefits after mistakenly paying benefits, BCI may still enforce this provision. This provision is in addition to, not instead of, any other remedy BCI may have at law or in equity.

**XXXIII. Subrogation and Reimbursement Rights and Obligations of Blue Cross of Idaho**

The benefits of this Policy will be available to an Insured when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by Blue Cross of Idaho under this Policy or any other Blue Cross of Idaho plan, agreement, certificate, contract or policy, Blue Cross of Idaho shall be subrogated and succeed to the rights of the Insured or, in the event of the Insured's death, to the rights of his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Insured or his or her personal representative shall furnish Blue Cross of Idaho in writing with the names and addresses of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Insured or his or her personal representative concerning the injury, harm or loss.

Blue Cross of Idaho may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Insured's right to receive payments from other parties. The Insured or his or her legal representative will transfer to Blue Cross of Idaho any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Insured. Thus, Blue Cross of Idaho may initiate litigation at its sole discretion, in the name of the Insured, against any third party or parties. Furthermore, the Insured shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho's subrogation rights and efforts. Blue Cross of Idaho will be reimbursed in full for all benefits paid even if the Insured is not made whole or fully compensated by the recovery.

Additionally, Blue Cross of Idaho may at its option elect to enforce its right of reimbursement from the Insured, or his or her legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Insured shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho's reimbursement rights and efforts.

The Insured shall pay Blue Cross of Idaho as the first priority, and Blue Cross of Idaho shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by Blue Cross of Idaho under this Policy, regardless of how the recovery is allocated (*i.e.*, pain and suffering) and whether the recovery makes the Insured whole. Thus, Blue Cross of Idaho will be reimbursed by the Insured, or his or her legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Insured is not made whole or fully compensated by the recovery.

To the extent that Blue Cross of Idaho provides or pays benefits for Covered Services, Blue Cross of Idaho's rights of subrogation and reimbursement extend to any right the Insured has to recover from the Insured's insurer, or under the Insured's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

Blue Cross of Idaho shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Insured, the Insured's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Insured including the Insured's attorney.

Blue Cross of Idaho's subrogation and reimbursement rights shall take priority over the Insured's rights both for expenses already incurred and paid by Blue Cross of Idaho for Covered Services, and for benefits to be provided or payments to be made by Blue Cross of Idaho in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho's subrogation and reimbursement rights. Further, Blue Cross of Idaho's subrogation and reimbursement rights for incurred expenses and/or future expenses yet to be incurred are primary and take precedence over the rights of the Insured, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Insured and Blue Cross of Idaho.

Collections or recoveries made in excess of such incurred Blue Cross of Idaho expenses shall first be allocated to such future Blue Cross of Idaho expenses, and shall constitute a special Deductible applicable to such future benefits and services under this or any subsequent Blue Cross of Idaho policy. Thereafter, Blue Cross of Idaho shall have no obligation to make any further payment or provide any further benefits until the benefits equal to the special Deductible have been incurred, delivered, and paid by the Insured.

## XXIV. Independent Blue Cross And Blue Shield Plans

The Group (on behalf of itself and its participants), hereby expressly acknowledges its understanding this Policy constitutes a contract solely between the Group and BCI, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, as association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCI to use the Blue Cross and Blue Shield Service Marks in the state of Idaho, and that BCI is not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Policy based upon representations by any person, entity, or organization other than BCI and that no person, entity, or organization other than BCI shall be held accountable or liable to the Group for any of BCI's obligations to the Group created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of BCI other than those obligations created under other provisions of this Policy.

**XXV. Statements**

In the absence of fraud, all statements made by an applicant, or the policyholder, or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the enrolled person.

**XXVI. Membership, Voting, Annual Meeting And Participation**

The Group, as the policyholder, is a member of BCI and is entitled to vote in person or by proxy at the meetings of policyholders. The Group shall designate to BCI in writing the person who has the right to vote in person or by proxy on behalf of the Group. The annual meeting of policyholders of BCI is held on the last Friday of April of each year at 2:00 p.m., at the corporation's registered office, 3000 East Pine Avenue, Meridian, Idaho. This notice shall be sufficient as to notification of such annual meetings. If any dividends are distributed, the policyholders shall share in them according to the articles of incorporation and bylaws of BCI and under the conditions set by the board of directors of BCI.

**XXVII. Replacement Coverage**

If this Policy replaces prior Group coverage within sixty (60) days of the date of termination of prior coverage, BCI shall immediately cover all employees and dependents validly covered under the prior coverage at the date of termination who meet the Group's eligibility requirements and who would otherwise be eligible for coverage under this Policy, regardless of any exclusions or limitations relating to active employment or nonconfinement.

The previous paragraph is subject to all other provisions of Idaho Code Section 41-2215, including BCI's right to deduct from any benefits becoming payable under this Policy the amount of benefits under the prior Group coverage pursuant to an extension of benefits provision for Insureds who are Totally Disabled.

**XXVIII. Individual Benefits Management**

Individual Benefits Management allows BCI to provide alternative benefits in place of specified Covered Services when alternative benefits allow the Insured to achieve optimum health care in the most cost-effective way.

The decision to allow alternative benefits will be made by BCI in its sole and absolute discretion on a case-by-case basis. BCI may allow alternative benefits in place of specified Covered Services when an Insured, or the Insured's legal guardian and his or her Physician concur in the request for and the advisability of alternative benefits. BCI reserves the right to modify, limit, or cease providing alternative benefits at any time.

A determination to cover alternative benefits for an Insured shall not be deemed to waive, alter, or affect BCI's right to reject any other requests or recommendations for alternative benefits.

**XXIX. Coverage And Benefits Determination**

BCI is vested with authority and discretion to determine whether a claim for benefits is covered under the terms of this Policy, based on all the terms and provisions set forth in this Policy, and also to determine the amount of benefits owed on claims which are covered.

**XXX. Health Care Providers Outside the United States**

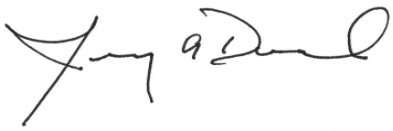
The benefits available under this Policy are also available to Insureds traveling or living outside the United States. Reimbursement for Covered Services will be made directly to the Insured. BCI will require the original claim along with an English translation. It is the Insured's responsibility to provide this information.

BCI will reimburse covered Prescription Drugs purchased outside the United States by Insureds who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Insureds are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of drugs originally prescribed and purchased in the United States is necessary. The reimbursable supply of drugs in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

Finally, there are no benefits for services, supplies, drugs or other charges that are provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Policy.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this Policy.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707



Jerry A. Dworak
Sr. VP & Chief Marketing Officer
Sales & Marketing